STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155319	A. BUILDING 00 B. WING	03/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON GARDENS	375 S 11TH ST CLINTON, IN 47842

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F0000	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00105028 and IN00104612. Complaint #IN00104612-Unsubstantiated due to lack of evidence. Complaint #IN00105028-Substantiated. Federal/state deficiencies related to the allegation are cited at F315 and F353. Survey dates: March 15, 16, 21-23, 26-28, 2012 Facility Number: 000212 Provider Number: 155319 AIM Number: 100285040 Survey Team: Laura Brashear, RN, TC Mary Weyls, RN Teresa Buske, RN Debra Skinner, RN, 3/16/12 Census bed type: SNF/NF: 76 Total: 76	F0000	The creation and submission of the Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.This provider respectfully requests that the 2567L Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Review on or after April 27, 2012.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Census payor type: Medicare: 15 Medicaid: 46 Other: 15 Total: 76 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on April 4, 2012 by Bev Faulkner, R.N.			

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F0241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, interview, and record review, the facility failed to assist residents in a timely manner to prevent incontinence for 2 of 3 residents reviewed for dignity in the sample of 3 who met the criteria for dignity. [Residents G and B] Findings include: 1. On 3/16/12 at 11:00 a.m., Resident G was observed to have her call light turned on. LPN #7 answered the call light, turned the light off and indicated to the resident she would get CNA #1 to help her. The nurse indicated one of the CNAs assigned to the unit was on lunch and sometimes residents get backed up on toileting. On 3/16/12 at 11:15 a.m., the resident was interviewed. The resident put the call light on and indicated she needed assistance to toilet. At 11:43 a.m., CNA #2 entered the room and asked the resident what she needed. The resident responded	F0241	Dignity and Respect of Individuality. It is the practice of this facility to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? *An inservice was held by the DNS on 04/12/12 and 04/17/12 for all direct care staff to educate regarding provisions of providing resident assistance in a timely manner to prevent incontinence and maintain or enhance dignity and respect. *CNA's were observed by the DNS in providing timely incontinence care to residents B & G. Any staff that demonstrated deficient practices in protocol were redirected to acceptable practice and required to give a return demonstration to demonstrate competency in skills and techniques as it relates to efficient incontinence care. *Residents B & G call lights are being answered timely and care is being provided timely. *Residents B & G were provided	04/27/2012

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	and CNA #2 exited the room. CNA #1 entered the room right after CNA #2 had exited and started to take the resident in the wheelchair to the dining room. At this time, CNA #1 was informed the resident needed to use the bathroom. CNA #1 indicated she would have to get another CNA to help her and exited the room. CNA #2 returned and indicated to the resident she would return as soon as she was done delivering condiments to other residents on the unit having lunch in their rooms. On 3/16/12 at 11:45 a.m., CNAs #1 and #2 returned to the resident's room with a mechanical lift. The resident was transferred to the bed, placed on a bedpan and was observed to have been incontinent of bowel. During the interview of the resident on 3/16/12 at 11:15 a.m., the resident indicated sometimes she has to wait over an hour and a half for assistance with toileting. The resident indicated they needed more help and indicated she knew she has been on the call light too much at times. Resident G's clinical record was reviewed on 3/26/12 at 1:41 p.m. The Minimum Data Set [MDS] with		an observation of a 3 day voiding pattern to determine their typical voiding schedules. Results were updated in the resident care plans and the CNA pocket tools for notification of any changes and consistency of care. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? *All dependent residents have the potential to be affected. *All dependent residents will be reassessed for voiding patterns using the Bladder Assessment, including a 3 day voiding pattern assessment. Any resident admitted to the facility will be assessed upon admission. *An inservice was held by the DNS on 04/12/12 and 04/17/12 for all direct care staff to educate regarding resident assistance in a timely manner to prevent and manage incontinence. What measure will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? *The DNS/Designee shall perform random audits/facility rounds daily X3 shifts to monitor resident incontinence and timeliness of care using CNA Proficiency Standards. *Residents will be interviewed using the CQI Resident Care Rounds Tool to ensure compliance. *Staff found not to respond to call lights promptly and/or not provide care promptly will be addressed	

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	assessment reference date of 1/10/12, coded the resident with moderate cognitive impairment., no toileting plan, and as frequently incontinent of bowel (2 or more episodes with at least one continent episode) and bladder (7 or more episodes of urinary incontinence but at least one episode of continent voiding). The Resident Care Sheet, dated 3/27/12, included, but was not limited to, requires mechanical lift with assistance of two for transfers. Assist of two for activities of daily living, toileting program of T-time [i.e. upon rising, before and after meals, at hour of sleep and prn] and pull ups. 2. On 3/15/12 at 2:30 p.m., Resident B was sitting in a wheelchair on the E unit hallway. CNA #3 was picking up water pitchers. The resident indicated to CNA #3 "Please, I've got to go to the toilet." CNA #3 indicated "Just a minute." The CNA kept picking up water pitchers. The resident		immediately. *All employees are educated on dignity and respect upon hire. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? *The DNS/Designee will audit the timeliness of call light response for a minimum of 5 staff member daily, to include all shifts, for the next 30 days. Any non-compliance will be immediately corrected. *To ensure compliance, the DNS/Designee is responsible for the completion of Resident Care Rounds CQI tool weekly times 4 weeks, bi-monthly time 2 months, and then quarterly until continued compliance is manitained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance including possible disciplinary action up to termination.	

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	responded "Please, oh come on now." At 2:40 p.m., CNA # 1 pushed the resident to the activity room. Staff was not present. Resident B indicated, "I told them I wanted to go to the bathroom and they didn't take me, now I ' m wet. The resident's pants were observed wet. At 2:45 p.m., CNAs #1 and #3 were on E unit standing at a desk looking at paper work, talking about assignments. At 2:50 p.m., RN #5 was pushing Resident B back to the unit. The RN indicated to CNAs # 1 and #3 "She's wet and needs to be cleaned up." At 2:55 p.m., CNAs #1 and #3 took Resident B to the resident's room. The resident gave permission for observation of care by stating "It's all right as long as I get changed." CNA #3 asked the resident "Are you ok?" The resident responded "No." CNA #3 asked the resident "what is wrong?" The resident replied "Wet pants, I hate the feel of wet pants." A heavy urine odor was observed in the room. A facility policy titled "Resident Rights," dated January 2006, was received from the DON on 3/28/12 at 3 p.m. Documentation indicated under the heading of "Resident Rights" that the resident had the right to a dignified existence, self			

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	determination, and communication with and access to persons and services inside and outside the facility 3.1-3(t)			

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F0242 SS=E	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.			
	Based on record review and interview, the facility failed to ensure residents were able to choose their morning routine for 2 of 3 residents (Resident D and H) interviewed from the sample of 3 who met the criteria for choices. This potentially affected 8 residents from each of 3 of 3 units in the facility for a total of 24 residents requiring assistance of one or two with dressing. Findings include: 1. During interview of Resident D on 3/23/12 at 9:48 a.m., the resident indicated she is woken up at 4:30 a.m. to be bathed and dressed. The resident indicated, "I've told them [CNAs] but they don't pay attention. This morning they got me up at 4:45 a.m., and dressed me. They would let you lay back down, but who wants to lay back down after that? They get you up so early. I can stay up later	F0242	Self-Determination- Right to Make Choices. It is the practice of this facility to allow residents to have the right to choose activities, schedules and health care consistent with his or her interests, assessments, and plan of care. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? *Residents D and H were reinterviewed by the Activity Director for their choice of morning routine schedule, using the Preferences for Daily Customary Routines form. Resident responses were placed on the CNA pocket tool and care plans were updated. *Residents D and H are now getting up per their choice. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? *All residents have the potential to be affected. *All residents will be reassessed for choices of morning routines using the Preferences for Daily Customary	04/27/2012

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	but I go to bed earlier because I wouldn't get enough sleep. I've told the aides I don't want to get up that early, but they say they have so many people they have to get dressed." Resident D's clinical record was reviewed on 3/26/12 at 3:30 p.m. A significant change [MDS] Minimum Data Set assessment, dated 1/22/12, coded the resident with moderate cognitive impairment. The assessment coded the resident as requiring extensive assistance with transfers and toileting and extensive assistance of one for dressing and hygiene. During interview of CNA # 1 on 3/27/12 at 9 a.m., the CNA indicated the night shift is supposed to have around 6 to 7 residents up and dressed when the day shift comes in at 6 a.m. The CNA indicated Resident D was dressed when the CNA came in at 6 a.m., but was laying back down this morning. During interview of the ADON (Assistant Director of Nursing) on 3/27/12 at 9:30 a.m., the ADON indicated each unit is expected to		Routines form. Resident responses will be placed on the CNA pocket tool and care plans will be updated. Any resident admitted to the facility will be assessed upon admission. What measures will be put into place for what systemic changes you will make to ensure that the deficient practice does no recur? *All newly admitted residents will be assessed for choices of morning routines using the Preferences for Daily Customary Routines form by the Activity Department as part of their normal admission assessment process. Resident responses will be placed on the CNA pocket tool and care plans will be updated. *Nursing staff have been reeducated related to allow residents to have the right to choose activities, schedules and healthcare consistent with his or her interests, assessments, and plan of care. Specifically regarding choice of morning routine. *Resident choices are placed in the ADL book. Licensed nurse will monitor the ADL book daily to ensure residents' choices are being met. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? *To ensure compliance, the DNS/Designee is responsible for the completion of Resident Care Rounds CQI tool weekly	

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	have at least eight residents up. We don't specify which residents they have to get up. 2. During interview of Resident H on 3/15/12 at 2:49 p.m., the resident indicated she gets up between 4 a.m. and 5:30 a.m. The resident indicated if she had a choice she would get up at 9 a.m. The resident also indicated the staff doesn't force her to get up, but that they encourage her. The resident stated she required assistance to get up. Review of the clinical record of Resident H on 3/27/12 at 2 p.m., indicated the most recent Minimum Data Set (MDS) assessment was completed 1/16/12. The assessment identified the resident with moderate impairment of cognitive decision making skills, and extensive assistance with transfers, dressing, eating, hygiene, and bathing. Interview of CNA #10 on 3/28/12 at 12:05 p.m., indicated the night shift was supposed to be getting 8		times 4 weeks, bi-monthly times 2 months, and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If a threshold of 95% is not achieved an action plan will be developed to ensure compliance, including possible disciplinary action up to termination.	

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	residents dressed and up on each unit before we come in on day shift. Interview of RN #5 on 3/27/12 at 11:45 a.m., indicated the night shift staff get four to eight residents up during their shift and that they usually started getting residents up between 4-5 a.m. A facility policy titled "Resident Rights," dated January 2006, was received from the DON on 3/28/12 at 3 p.m. Documentation indicated under the heading of "Quality of Life" that the resident had the right to make choices about aspects of his or her life in the facility that are significant to the resident. 3.1-3(u)(1)			

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F0280 SS=A	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on interview and record review, the facility failed to notify 1 of 3 resident's family members interviewed regarding care plan conferences. [Resident #69] Finding includes: On 3/21/12 at 11:00 a.m., Resident #69's family representative was interviewed. The family member indicated he was the resident's representative and was the person who would be notified of any change in condition or notified of care planning conferences. The family	F0280	Right to Participate Planning Care- Revise CP It is the practice of this facility to notify and review plans of care as prepared by an interdisciplinary team to include the participation of the resident, the resident's family or the resident's legal representative. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? *The family representative has been contacted regarding the care plan conference for resident #69 and scheduled on 04/12/12 at 1:00 p.m. Although an official meeting was scheduled on this date, note that the family representative is at the facility almost daily and has	04/27/2012

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	member indicated he had not been made aware of the conferences in the last couple of years. Resident #69's clinical record was reviewed on 3/27/12 at 10:49 a.m. The Minimum Data Set [MDS] assessment with reference date of 9/6/11 coded the resident with severe cognitive impairment. A form titled "Interdisciplinary Care Plan Review/Meeting," provided by the Social Service Director on 3/27/12 at 1:50 p.m., included, but was not limited to, documentation of persons attending the resident's care plan conferences. The most recent conference date was noted of 2/6/12. The most recent documentation of family attendance was noted of 2/24/11. The SSD was interviewed on 3/27/12 at 1:45 p.m. The SSD indicated she and the Minimum Data Set [MDS] Coordinator were the persons responsible for notifications to resident/family regarding care plan meetings. The SSD indicated the system may have gone by the wayside as both staff had extended absences due to medical reasons. The SSD indicated the system had been re-instituted. The SSD indicated If documentation of family was lacking		open communication with the licensed nurse, CNA's and administration. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? *All residents have the potential to be affected. *Social Service Designee and MDS Coordinator will schedule care plan conferences for each resident quarterly, annually, significant change and/or as requested by resident/resident family. The interdisciplinary team will be provided a monthly schedule and updates as needed. Care plan scheduling will coordinate with the MDS process. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?* The care plan conference schedule will collaborate with the MDS process schedule. Social Services will mail an invitation post card to family members and obtain a copy in the care plan schedule binder. How the corrective actions will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place?*The MDS Coordinator will audit care plan conference participation at least quarterly to ensure review of plans of care are held with the participation of the resident, the resident's family or the resident's	

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	on the care plan meeting form they may not have been notified. The SSD indicated documentation of resident or family representatives notifications of meetings had not previously been maintained. A facility policy titled "Care Plan Review and Maintenance Process," with revision date of 8/2/11 provided by the SSD on 3/27/12 at 1:50 p.m., included, but not limited to, "Resident, resident's families or others as designated by resident will be invited to care plan review." 3.1-35(c)(2)(C)		legal representative. Any non-compliance will be immediately corrected.*To ensure compliance, the MDS Coordinator and Social Service Designee is responsible for the completion of the Care Plan Review CQI Tool weekly times 4 weeks, bi-monthly times 2 month, and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If a threshold of 95% is not achieved, an action plan will be developed.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview and record review, the facility failed to provide personal hygiene for 2 of 4 residents dependent for incontinence care observed, in that skin was not thoroughly cleansed after being incontinent of urine. [Resident #71 and Resident B] Findings include: 1. On 3/22/12 at 12:40 p.m., Resident #71 was observed to be incontinent of urine. A strong urine odor was noted in the resident's room. CNAs #1 and #11 were observed to lift Resident #71 with the stand up mechanical lift. The resident was observed to have been incontinent of urine and her slacks were visibly wet from the knees to the waist band. The resident was transferred to bed. The resident's slacks and saturated incontinence brief were removed. The CNAs provided peri-care. The back of the resident's legs that had been in contact with the resident's wet slacks were observed not to have been	F0312	ADL Care Provided for Dependent Residents. It is the practice of this facility to carry out activities of daily living necessary to maintain good nutrition, grooming, and personal and oral hygiene. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? *CNA's were observed by the DNS for providing proper personal hygiene for Resident's #71 and B. Any staff that demonstrated deficient practices in protocol were redirected to acceptable practice and required to give a return demonstration to demonstrate competency in skills and techniques as it relates to efficient incontinence care and personal hygiene. *Nursing staff have been reeducated by the DNS on 04/12/12 and 04/17/12 related to proper personal hygiene provided to residents for incontinence care and thoroughly cleansing of the skin from urine. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? *All incontinent residents have the potential to be affected. *The	04/27/2012

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	cleansed. Resident #71's clinical record was reviewed on 3/27/12 at 4:28 p.m. The resident's diagnoses included, but was not limited to Alzheimer's disease, dementia, and kidney disease. The Minimum Data Set [MDS] assessment with assessment reference date of 2/3/12, coded the resident with severe cognitive impairment, non-ambulatory, required extensive assistance of two for bed mobility and transfers, total assistance of one for dressing, extensive assistance of two for toilet use and frequently incontinent of bowel and bladder. A plan of care, dated 10/27/11, addressed the problem of potential for skin breakdown related to fragile skin, bruises easy. Approaches included, but was not limited to, assist resident with toileting and peri care after each incontinent episode.		DNS/Designee shall perform random audits/facility rounds to monitor resident incontinence and proper personal hygiene standards. Resident's will also be interviewed using the CQI Resident Care Rounds Tool to ensure compliance. *Nursing staff have been reeducated related to proper personal hygiene to residents for incontinence care and thoroughly cleansing of the skin from urine by the DNS on 04/12/12 and 04/17/12. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? *All CNA's will perform a skills validation in proper technique for providing incontinence care by SDC/designee by 04/27/2012. Any process of personal hygiene that is noncompliant will be immediately redirected. *An inservice held by the DNS on 04/12/12 and 04/17/12 for all direct care staff to educate staff regarding proper personal hygiene for dependent residents with incontinence and the importance of thoroughly cleansing the skin of urine. How the corrective actions will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place? *The DNS will audit that dependent residents have received proper personal hygiene during regular room rounds and observation of	

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	2. On 3/15/12, at 2:55 p.m., CNAs #1 and #3 took Resident B to the resident's room. The CNAs transferred the resident to bed utilizing a Arjo maxi-move lift. The resident's slacks were wet up to the waist band and down to the middle of the resident's thighs. The resident's incontinence brief was heavy with urine. The CNAs washed the resident's peri-area. The CNAs were observed not to cleanse the thigh areas that had been in contact with the wet slacks. A plan of care, dated 10/22/11,		incontinence care via the CNA skills validation for the next 30 days. Any noncompliance will be immediately corrected. *To ensure compliance, the DNS/Designee is responsible for the completion of Resident Care Rounds CQI tool weekly times 4 weeks, bi-monthly times 2 months, and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If a threshold of 95% is not achieved, and action plan will be developed to ensure compliance, including possible disciplinary action up to termination.	

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	addressed the resident was at risk for adverse affects of incontinence and required assistance with incontinence care as needed check every two hours for incontinence. During interview of the Assistant Director of Nursing (ADON) on 3/28/12 at 5:15 p.m., the ADON indicated the resident's skin that was in contact with urine should have been cleansed. 3.1-38(a)(3)(A)			

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F0315 SS=E	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation, record review and interview, the facility failed to provide timely services to restore as much bladder function as possible for 4 of 16 residents (Residents B, E,F, and G) reviewed requiring assistance with toileting, in that the residents were not being assisted in a timely manner. Findings include: 1. On 3/15/12 at 2:30 p.m., Resident B was sitting in a wheelchair on the E unit hallway. CNA #3 was picking up water pitchers. The resident indicated to CNA #3, "Please, I've got to go to the toilet." CNA #3 indicated, "Just a minute." The CNA kept picking up water pitchers. The resident responded, "Please, oh come on now." At 2:40 p.m., CNA # 1 pushed	F0315	No Catheter, Restore, Bladder It is the practice of this facility to ensure that a resident who enters the facility who is incontinent of bladder receives appropriate treatment and services to restore as much normal bladder function as possible. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? *Resident's B, E, F and G were provided an observation of a 3 day voiding pattern to determine their typical voiding schedules. Results were updated in the careplans and CNA pocket tools for notification of any changes. *Bladder Assessments have been completed for Resident B, E, F, and G. *Licensed nursing staff have been inserviced by the SDC/Designee regarding bladder assessments and the process of a 3 day voiding pattern by 04/27/2012. *An inservice held by the DNS on 04/12/12 and 04/17/12 for all	04/27/2012

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	the resident to the activity room. Staff was not present. Resident B indicated, "I told them I wanted to go to the bathroom and they didn't take me, now I'm wet. The resident's pants were observed wet. At 2:45 p.m., CNAs #1 and #3 were on E unit standing at a desk looking at paper work and talking about assignments. At 2:50 p.m., RN #5 was pushing Resident B back to the unit. The RN indicated to CNAs # 1 and #3 "She's wet and needs to be cleaned up." At 2:55 p.m.,CNAs #1 and #3 took Resident B to the resident's room. The resident gave permission for observation of care stating. "It's all right as long as I get changed." CNA #3 asked the resident "Are you ok?" The resident responded "No." CNA #3 asked the resident "What is wrong?" The resident replied "Wet pants, I hate the feel of wet pants." A heavy urine odor was observed in the room. The CNAs transferred the resident to bed utilizing a Arjo maxi-move lift. The resident's slacks were wet up to the waist band and down to the middle of the resident's thighs. The resident's incontinence brief was heavy with urine. On 3/16/12 at 10:50 a.m., Resident		direct care staff to educate on proper toileting plans for residents and bladder assessments. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? *All dependent residents have the potential to be affected. *All dependent residents will be reassessed for voiding patterns using the bladder assessment, including a 3 day voiding pattern assessment. New residents admitted to the facility will be assessed upon their admission. *Nursing staff have been inserviced on bladder assessments and 3 day voiding pattern by the SDC/Designee by 04/27/2012. *An inservice held by the DNS on 04/12/12 and 04/17/12 for all direct care staff to educate on proper toileting plans for residents and bladder assessments. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? *Bladder assessments are completed upon admission, quarterly, and with significant. Assessments will be reviewed during regular MDS schedules. *Three day voiding patterns will be reviewed by the IDT and resident's will placed on a toileting plan based on the pattern review to ensure as much bladder function, as possible. *Care plans will be updated to	

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	B's son was standing in the resident's doorway. The son indicated the resident needed to go bathroom, but the staff are busy. The son indicated he had told the nurse and the nurse had told the CNAs. The son indicated this is not a good time because of staff lunch breaks. At 11:00 a.m., the son indicated to the resident "go ahead and go if you have to." At 11:15 a.m., CNAs #1 and #2 transferred the resident, utilizing a stand up lift, from the wheelchair to the toilet. The incontinence brief was observed wet with a smear of feces. The resident urinated in the toilet. On 3/26/12 at 12:53 p.m., Resident B's clinical record was reviewed. An admission date of 4/18/07 was noted. A quarterly assessment, dated 2/28/12, identified the resident as requiring extensive assist of two persons for transfers and toilet use. A bladder continence assessment, dated 2/27/12, indicated the resident was frequently incontinent. The section of the assessment titled "Comprehension of toileting needs"		reflect current status. *Licensed nurse will monitor daily to ensure each toileting program is followed. *An inservice held by the DNS on 04/12/12 and 04/17/12 for all direct care staff to educate on proper toileting plans for residents and bladder assessments. How the corrective actions will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place? *Nursing staff have been inserviced on bladder assessments and 3 day voiding pattern by the SDC/Designee by 04/27/12. *An inservice held by the DNS on 04/12/12 and 04/17/12 for all direct care staff to educate on Bladder Assessments and 3 day voiding pattern and proper toileting plans. *To ensure compliance, the DNS/Designee is responsible for the completion of Resident Care Rounds CQI tool weekly times 4 weeks, bi-monthly times 2 months, and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If a threshold of 95% is not achieved, and action plan will be developed to ensure compliance, including possible disciplinary action up to termination.	

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	with questions of, but not limited to, "Can the resident comprehend and follow simple instruction?" and "Can the resident identify the urge to urinate?," was not filled out. The section of the assessment titled "Conclusion of Bladder assessment" with a question of "Is the resident mentally and physically aware of the need to void and be able to use the toilet, commode, urinal, or bedpan?" was not answered. A plan of care was noted, with a problem start date of 10/22/11, identifying the "Resident is at risk of adverse effects of incontinence, over active bladder", with approaches of but not limited to, of assist with incontinent care and check every two hours for incontinence. An approach to toilet the resident was lacking. 2. During interview of Resident E on 3/16/12 at 3 p.m., the resident indicated, "I've been here two months. Fell at home and broke my back. At first I thought the staff felt I was going to the bathroom too much. The call light takes a long time to answer. The staff will come in and tell you they will be back, but then they don't return. Yes, I've had accidents waiting for the staff			

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	to take me to the bathroom. Don't drink as much now, so don't have to go to the bathroom as much. I cut out my tea and coffee and if I'm thirsty at night I just take small sips of water." Resident E's clinical record was reviewed on 3/27/12 at 2:03 p.m. An admission date was noted of,1/9/12, with a diagnosis of, but not limited to, Lumbar 1 compound fracture after fall. A facility "Nursing Admission Assessment" was noted, dated 1/15/12. Documentation was noted indicating the resident was "Continent Prior to Admission." A "Bladder Continence Assessment" form was noted with Resident B's name. The form lacked a date and was not filled out. An Admission MDS, dated 1/22/12, indicated the resident was frequently incontinent of urine and requiring extensive assistance of two with transfers. The assessment also indicated the resident was without cognitive problems. The CAAs (care area assessment) documented the resident was alert with occasional confusion, able to make needs			

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	known, needs assist with activities of daily living, incontinent and needs assist with toileting/pericare. The CAAs did not indicate the cause of urinary incontinence. A plan of care, dated 2/1/12, indicated "Resident is at risk of adverse effects of incontinence...needs assist with toileting/pericare,..." An approach of "assist with incontinent care was noted." An approach to indicate a toileting plan was lacking. During interview of the MDS Coordinator on 3/27/12 at 3:15 p.m., the Coordinator indicated she fills out the assessment for continence. The staff person indicated she gets her information concerning urinary continence from the ADL (activities of daily living) record the CNAs fill out, which indicate the number of times the resident is incontinent of urine. The MDS person indicated the resident was not interviewed concerning her incontinence. 3. During interview of Resident F, on 3/16/12 at 2:30 p.m., the resident indicated she was having incontinent episodes due to waiting too long for staff assistance.			

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Resident F's clinical record was reviewed on 3/28/12 at 9:30 a.m.

A quarterly MDS, dated 2/28/12, indicated the resident was without cognitive problems, required extensive assist with transfers and toilet use, and was frequently incontinent of urine.

An annual MDS, dated 12/09/11, indicated the resident was without cognitive problems, required extensive assist with transfers and toilet use and was frequently incontinent. The CAAs documented "Resident has accidents with urinary incontinence secondary to her CVA [cerebral vascular accident] and decreased mobility. She is alert and toilets with assist of one staff. No specific time or program in place currently, resident will alert staff when she needs to go for the most part."

Review of the ADL sheets for February and March 2011, documentation indicated the resident was continent at times and incontinent at times.

A bladder continence assessment, dated 2/27/12, indicated the resident was frequently incontinent. The

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	section of the assessment titled "Comprehension of toileting needs" with questions of, but not limited to, "Can the resident comprehend and follow simple instruction?" and "Can the resident identify the urge to urinate?", was not filled out. Page 2 of the assessment was missing During interview of the MDS Coordinator on 3/28/12 at 9:33 a.m., the Coordinator indicated, "When I did that assessment I didn't realize there was a second page until after I had done another assessment for another resident." The MDS Coordinator indicated the second page of the assessment included information that provided the conclusion of the bladder assessment with a question of, but not limited to, concerning whether the resident would be mentally and physically aware of the need to void and be able to use the toilet, commode, urinal, or bedpan. . The MDS Coordinator indicated that part of the assessment had not been done. 4. On 3/16/12 at 11:00 a.m., Resident G was observed to have her call light turned on. LPN #7 answered the call light, turned the light off and indicated to the resident			

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	she would get CNA #1 to help her. The nurse indicated one of the CNAs assigned to the unit was on lunch and sometimes residents get backed up on toileting. On 3/16/12 at 11:15 a.m., the resident was interviewed. The resident put the call light on and indicated she needed assistance to toilet. At 11:43 a.m., CNA #2 entered the room and asked the resident what she needed. The resident responded and CNA #2 exited the room. CNA #1 entered the room right after CNA #2 had exited and started to take the resident in the wheelchair to the dining room. At this time, CNA #1 was informed the resident needed to use the bathroom. CNA #1 indicated she would have to get another CNA to help her and exited the room. CNA #2 returned and indicated to the resident she would return as soon as she was done delivering condiments to other residents on the unit having lunch in their rooms. On 3/16/12 at 11:45 a.m., CNAs #1 and #2 returned to the resident's room with a mechanical lift. The resident was transferred to the bed, placed on a bedpan and was observed to have been incontinent of bowel.			

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	During the interview of the resident on 3/16/12 at 11:15 a.m., the resident indicated sometimes she has to wait over an hour and a half for assistance with toileting. The resident indicated they needed more help and indicated she knew she has been on the call light too much at times. Resident G's clinical record was reviewed on 3/26/12 at 1:41 p.m. The Minimum Data Set [MDS] with assessment reference date of 1/10/12, coded the resident with moderate cognitive impairment, no toileting plan, and frequently incontinent of bowel and bladder. The Resident Care Sheet, dated 3/27/12, included, but was not limited to, requires mechanical lift with assistance of two for transfers. Assist of two for activities of daily living, toileting program of T-time [i.e. upon rising, before and after meals, at hour of sleep and prn] and pull ups. This federal tag relates to Complaint #IN00105028 3.1-41(a)(2)			

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CLINTON GARDENS	375 S 11TH ST CLINTON, IN 47842

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F0353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. Based on observation, record review and interview, the facility failed to provide adequate staffing assistance to prevent incontinence and/or to honor residents' choices for activities of daily living, for 8 of 16 residents identified requiring assistance with toileting/dressing, in that residents were not provided the services in a timely manner. Residents A, B, C, E, F,G, H, and I Findings include:	F0353	Sufficient 24 Hr Nursing Staff per Care Plans It is the practice of this facility to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? This facility employs sufficient staffing to provide nursing and related services. However, it has come	04/27/2012

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	1. On 3/15/12 at 2:30 p.m., Resident B was sitting in a wheelchair on the E unit hallway. CNA #3 was picking up water pitchers. The resident indicated to CNA #3, "Please, I've got to go to the toilet." CNA #3 indicated, "Just a minute." The CNA kept picking up water pitchers. The resident responded, "Please, oh come on now." At 2:40 p.m., CNA # 1 pushed the resident to the activity room. Staff was not present. Resident B indicated, "I told them I wanted to go to the bathroom and they didn't take me, now I'm wet." The resident's pants were observed wet. At 2:45 p.m., CNAs #1 and #3 were on E unit standing at a desk looking at paper work and talking about assignments. At 2:50 p.m., RN #5 was pushing Resident B back to the unit. The RN indicated to CNAs # 1 and #3 "She's wet and needs to be cleaned up." At 2:55 p.m., CNAs #1 and #3 took Resident B to the resident's room. The resident gave permission for observation of care indicating, "It's all right as long as I get changed." CNA #3 asked the resident "Are you ok?" The resident responded "No." CNA #3 asked the resident "What is wrong?" The resident replied, "Wet pants, I hate the feel of wet pants." A heavy urine odor was observed in the room.		to our attention that our nursing staff need educated for time management skills and priority of performed job duties. *An inservice was held by the DNS on 04/12/12 and 04/17/12 for all direct care staff to educate resident assistance in a timely manner to prevent incontinence and/or honor resident choices for ADL care in a timely manner. *Resident A, B, C, E, F, G, H and I were included in the overall reassessment of a 3 day voiding pattern to determine their typical voiding schedules. Results were updated in the careplans and CNA pocket tools for notification of any changes. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? *All residents have the potential to be affected. *All residents will be assessed for voiding patterns using the bladder assessment, including a 3 day voiding pattern assessment. Any newly admitted resident will be assessed upon admission.*Nursing staff have been reeducated on following resident's plan of care while using time management skills and properly prioritizing job duties. Any changes will be noted on the CNA pocket tool and the resident care plan updated.What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?*CNA's	

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	On 3/16/12 at 10:50 a.m., Resident B's son was standing in the resident's doorway. The son indicated the resident needed to go bathroom, but the staff were busy. The son indicated he had told the nurse and the nurse had told the CNAs. The son indicated this is not a good time because of staff lunch breaks. At 11:00 a.m., the son indicated to the resident "Go ahead and go if you have to." During interview of CNA # 1 on 3/16/12 at 11:15 a.m., the CNA indicated concerning assignments, "It's rough and the resident's are the ones that pay." 2. During interview of Resident E on 3/16/12 at 3 p.m., the resident indicated "I've been here two months. Fell at home and broke my back. At first I thought the staff felt I was going to the bathroom too much. The call light takes a long time to answer. The staff will come in and tell you they will be back, but then they don't return. Yes, I've had accidents waiting for the staff to take me to the bathroom. Don't drink as much now, so don't have to go to the bathroom as much. I cut out my tea and coffee and if I'm thirsty at night I just take small sips of water."		have been provided with proper reeducation regarding incontinent residents and time management skills. All updates will be placed on the CNA pocket tool for resident care. In addition, resident care plans will be updated upon admission, readmission, annually, quarterly, and upon significant change.*CNA working schedules have also been adjusted to add one staff member to split their time between day shift and evening shift to provide more coverage for timely incontinence care during high traffic times of the day.How the corrective actions will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place?*The DNS/Designee shall perform random audits/facility rounds to monitor resident assistance with toileting/dressing and proper personal hygiene standards. Resident's will also be interviewed using the CQI Resident Interview to ensure compliance.*Licensed nurses will monitor call light response time and provision of care to ensure timely incontinence care.*Staff found to not answer call lights promptly and/or not provide care promptly will be addressed immediately.*To ensure compliance, the DNS/Designee is responsible for the completion of Resident Care Rounds CQI tool	

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	An admission MDS [Minimum Data Set] assessment, dated 1/22/12, indicated the resident was frequently incontinent of urine and required extensive assistance of two with transfers. The assessment also indicated the resident was without cognitive problems. The CAAs (care area assessment) documented the resident was alert with occasional confusion, able to make needs known, needs assist with activities of daily living, incontinent and needs assist with toileting/pericare. The CAAs did not indicate the cause of urinary incontinence. 3. During interview of Resident F on 3/16/12 at 2:30 p.m., the resident indicated she was having incontinent episodes due to waiting too long for staff assistance. Resident F's clinical record was reviewed on 3/28/12 at 9:30 a.m. A quarterly MDS, dated 2/28/12, indicated the resident was without cognitive problems, required extensive assist with transfers and toilet use, and was frequently incontinent of urine.		weekly times 4 weeks, bi-monthly times 2 months, and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If a threshold of 95% is not achieved, and action plan will be developed to ensure compliance, including possible disciplinary action up to termination.	

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	4. During interview of Resident A on 3/15/12 at 3:31 p.m., the resident indicated "Yes, I have accidents waiting for the staff to come. They can't help it. They are very nice to me and help me get cleaned up." Resident A's clinical record was reviewed on 3/17/12 at 1:54 p.m. An admission date was noted of 1/9/12. An admission MDS, dated 1/16/12, indicated the resident as having moderate cognitive impairment, requiring extensive assistance of two with transfers and frequently incontinent of bladder. The CAAs documented the resident was admitted due to a fall resulting in a left hip fracture. Was alert with intermittent confusion, had been admitted with a Foley catheter, but was now removed, receives diuretics and uses a bedpan at night. A bladder continence assessment, dated 1/21/12, indicated the resident was "Always Continent". A nurse's note, dated 3/26/12 at 2:35 a.m., indicated the resident was continent of bowel and bladder, toileted per staff, and had occasional			

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	urinary incontinence. IPN (Interdisciplinary Progress Notes), dated 2/14/12 at 9 a.m., indicated " ....Up in wheelchair more often ...Cont of B &B." 5. On 3/27/12 at 9:40 a.m., Resident C was observed in bed. The ADON (Assistant Director of Nursing) took a bedpan out from under the resident. Three incontinence pads were noticed under the resident. The resident indicated "When I have to go, I have to go. I feel so bad for the girls when I can't hold it. They work so hard and then they have to change my bed." During interview of Resident C on 3/28/12 at 9 a.m., the resident indicated she has had accidents waiting for the bedpan, but if the girls are helping someone else they can't help it. Resident C's clinical record was reviewed on 3/28/12 at 10:00 a.m. A Minimum Data Set [MDS] assessment, completed on 3/3/12, coded the resident with no cognitive impairment, required extensive assistance of two for toileting and was frequently incontinent of urine.			

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6. During interview with the Assistant Director of Nursing on 3/27/12 at 9:30 a.m., the ADON indicated if night shift doesn't get some of the resident's up on their shift, it's hard for the day shift to get everything done.

7. During interview of Resident H on 3/15/12 at 3:08 p.m., the resident indicated she felt that sometimes there were not enough staff to help her. The resident indicated the staff answer the call light, turn it off and then take too long coming back to take her to the bathroom. The resident indicated she has had accidents waiting too long and has waited longer than a half hour. The resident stated a nurse said "We work with what we have." The resident also indicated she has to wait longer on night shift and that the wait was recent.

Review of the clinical record of Resident H on 3/27/12 at 2 p.m., indicated the most recent Minimum Data Set (MDS) assessment was completed 1/16/12. The assessment identified the resident with moderate impairment of cognitive decision making skills, extensive assistance with toileting, and frequent incontinence of urine. The Activity of

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	Daily Living form for March 2012 indicated the resident was continent and incontinent for bladder function. The current plan of care addressed the problem of the resident required the FIT toileting program, dated 6/28/11, with approaches that included but were not limited to toilet upon rising, before and after meals, at bed time , and change at night as needed. Interview of CNA #10 on 3/28/12 at 12:05 p.m., indicated Resident H was only occasionally incontinent. 8. Interview of Resident I on 3/15/12 at 3:40 p.m., indicated he has had accidents with bowels waiting too long for staff to assist. The resident indicated the staff go and help others before they help him. Review of the clinical record of Resident I on 3/27/12 at 3:15 p.m., indicated the most recent Minimum Data Set (MDS) assessment was completed 2/3/12. The assessment identified the resident as independent in cognitive decision making skills and continent of bowel and bladder. 9. On 3/16/12 at 11:00 a.m., Resident G was observed to have her call light turned on. LPN #7 answered the call light, turned the			

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	light off and indicated to the resident she would get CNA #1 to help her. The nurse indicated one of the CNAs assigned to the unit was on lunch and sometimes residents get backed up on toileting. On 3/16/12 at 11:15 a.m., the resident was interviewed. The resident put the call light on and indicated she needed assistance to toilet. At 11:43 a.m., CNA #2 entered the room and asked the resident what she needed. The resident responded and CNA #2 exited the room. CNA #1 entered the room right after CNA #2 had exited and started to take the resident in the wheelchair to the dining room. At this time CNA#1 was informed, the resident needed to use the bathroom. CNA #1 indicated she would have to get another CNA to help her and exited the room. CNA #2 returned and indicated to the resident she would return as soon as she was done delivering condiments to other residents on the unit having lunch in their rooms. On 3/16/12 at 11:45 a.m., CNAs #1 and #2 returned to the resident's room with a mechanical lift. The resident was transferred to the bed, placed on a bedpan and was observed to have been incontinent of			

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	bowel. During the interview of the resident on 3/16/12 at 11:15 a.m., the resident indicated sometimes she has to wait over an hour and a half for assistance with toileting. The resident indicated they needed more help and indicated she knew she has been on the call light too much at times. Resident G's clinical record was reviewed on 3/26/12 at 1:41 p.m. The Minimum Data Set [MDS] with assessment reference date of 1/10/12, coded the resident with moderate cognitive impairment. no toileting plan, and frequently incontinent of bowel and bladder, required extensive assistance of two for transfers and toileting. The Resident Care Sheet, dated 3/27/12, included, but was not limited to, requires mechanical lift with assistance of two the toileting program of T-time [i.e. upon rising, before and after meals, at hour of sleep and prn]. 10. Review of the nursing schedule indicated four licensed nurses and six CNAs were routinely scheduled to provide care for 76 residents on the day shift. Four nurses and six CNAs			

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	were scheduled for evening shift and three nurses and four CNAs for night shift. Review of the Census and Condition report indicated that 56 residents required assistance of one or two for dressing, 45 required assist of one or two for transfers and 56 required assistance of one or two for toilet use. Fifty-one residents were identified as occasionally or frequently incontinent of bladder. This federal tag relates to Complaint #IN00105028 3.1-17(a)			

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